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IN THE

Supreme Court of the United States

OCTOBER TERM—1975

No. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

On Appeal from the Judgment of the United States District Court for the Middle District of Georgia

BRIEF AND APPENDIX OF *AMICUS CURIAE*, DEPARTMENT OF THE PUBLIC ADVOCATE, DIVISION OF MENTAL HEALTH ADVOCACY, STATE OF NEW JERSEY

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IN THE

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OCTOBER TERM, 1975

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T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

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BRIEF OF *AMICUS CURIAE*, DEPARTMENT OF THE PUBLIC ADVOCATE, DIVISION OF MENTAL HEALTH ADVOCACY, STATE OF NEW JERSEY

Summary of Argument

The Department of the Public Advocate, Division of Mental Health Advocacy, a statutory agency, has, since September 8, 1975, provided legal representation to individuals facing civil commitment proceedings, including juveniles, pursuant to *New Jersey Court Rule* 4:74-7, under a format comporting with procedural due process (Point I.A, B). *Amicus'* experience in providing such representation effectively rebuts those arguments raised by appellants alleging exacerbation of familial situations and traumatization of the child (Point I.C).

Similarly, relevant case law, scholarly literature and available empirical evidence further rebut such arguments by appellants (Point II).

Interest of *Amicus Curiae*

This case presents the significant issue of what process is due to juveniles facing civil commitment proceedings. *Amicus curiae,* Department of the Public Advocate, Division of Mental Health Advocacy, is an administrative agency of the State of New Jersey statutorily authorized to represent—both individually and on a class action basis—persons subject to such proceedings, on any issue pertinent to the commitment to, release from, or confinement in mental institutions throughout the State.[1] In this capac-

[1] For a discussion of the nature and scope of functions of the Division of Mental Health Advocacy in particular, see Perlin and Siggers, "The Role of the Lawyer in Mental Health Advocacy," 4 *Bull. Am. Acad. Psych. & L.* 205 (1976); Van Ness and Perlin,

(Footnote continued on following page)

ity, the Division of Mental Health Advocacy has undertaken to represent both adults and juveniles in commitment matters through procedures which satisfy the mandate of the District Court in this matter. *J.L.* v. *Parham,* 412 F. Supp. 141, 143 (M.D. Ga. 1976).

As will be discussed further, *infra* (see Point I.A.), the Division of Mental Health Advocacy has established two field offices[2] to provide representation, on an individualized basis, to residents of three counties[3] at commitment pro-

(Footnote continued from preceding page)

"The Mental Health Advocate: The New Jersey Experience," in Kopolow and Bloom, eds., *Mental Health Advocacy: An Emerging Force in Consumers' Rights* (N.I.M.H. ed. 1977) (in press); Note, "The Office of Public Counsel: Institutionalizing Public Representation in State Government," 64 *Geo. L.J.* 895, 900-902 (1976). See also, for discussions of the Department of the Public Advocate in general, Penn, "Advocate From Within," 12 *Trial Mag.* 20 (February 1976); Heffner, "Legislative Oversight: An Analysis of L.1974, Chapter 27, Department of the Public Advocate Act," *Seton Hall Leg. J.*, Vol. 1, No. 2 (Summer 1976), at 75; Note, "The Department of the Public Advocate—Public Interest Representation and Administrative Oversight," 30 *Rutgers L. Rev.* 386 (1977); Herr, *Advocacy Under the Developmental Disabilities Act* (Temple U. Publ. 1976).

For a specific discussion of the role of the Division in representing juveniles in the civil commitment process, see, Note, "Due Process Limitations on Parental Rights to Commit Children to Mental Institutions," 48 *U. Colo. L. Rev.* 235, 258 (1977).

[2] As of September 6, 1977, it is expected that these services will be expanded to another three counties as well. See footnote 4, *infra.*

[3] See footnote 4, *infra.*

ceedings, periodic review hearings, and individual matters concerning conditions of confinement or release.[4] Through this brief, the Division of Mental Health Advocacy hopes to apprise this Court of its experience in providing legal representation to juveniles subject to the civil commitment process.

The Division of Mental Health Advocacy files this brief as *amicus curiae* with the consent of all parties to this appeal. See letter from Joseph J. Levin, Jr., Counsel of Record for Appellees, and R. Douglas Lackey, Assistant Attorney General, State of Georgia, to Mr. Michael Rodak, Clerk, U. S. Supreme Court, set forth in the Appendix at 1a.

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[4] As noted *infra*, the original decision to establish two field offices was primarily premised on the availability of financial allocations. The entire Division operated on an annual budget of $550,698 in fiscal 1977. The three counties covered by the two field offices combined accounted for approximately 34% of the involuntary commitment proceedings initiated statewide in calendar year 1976 (total number of cases docketed January-December 1976: 3551; of those, 920 were from Essex County, 281 were from Mercer County, and 19 were from Hunterdon County).

The Division's appropriation has been increased to $789,795 for fiscal 1978, with $200,000 of the increase specifically allocated to enable the Division to establish another field office in Camden County to provide similar services to persons residing in Camden, Gloucester and Salem Counties. As 188 involuntary civil commitment cases were docketed from these three counties in calendar 1976 (131 from Camden, 34 from Gloucester and 23 from Salem), the Division will thus be assuming representation of 39% of all such proceedings beginning as of September 6, 1977.

It should also be noted that a bill currently before the New Jersey legislature, S.1674, would expand the Division statewide and mandate that it represent *all* persons subject to the civil commitment process (in addition to appreciably expanding its other representation and advocacy jurisdictions).

ARGUMENT

POINT I

I. The New Jersey Department of the Public Advocate, Division of Mental Health Advocacy has, since September 8, 1975, provided juveniles facing civil commitment proceedings representation in a manner similar to the procedural format mandated by the Court below.

A. The Division of Mental Health Advocacy is a statutory agency of the State of New Jersey charged with the responsibility to provide legal representation to individuals subject to involuntary civil commitment proceedings.

The Division of Mental Health Advocacy, a State agency within the New Jersey Department of the Public Advocate, has express statutory authority to

> provide such legal representation and medical consultation as the director deems appropriate for any indigent mental hospital admittee in any proceeding concerning the admittee's admission to, retention in, or release from confinement in such a hospital, institution or facility. N.J.S.A. 52:27E-24.

Pursuant to this statutory grant, and consonant with the available fiscal appropriations, the Division of Mental Health Advocacy (hereinafter "the Division") has established two field offices to provide legal counsel to individual "indigent mental hospital admitees."[5] These offices are

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[5] The Division also maintains a class action office, located in Trenton, with statewide jurisdiction and the statutory authority to

(Footnote continued on following page)

located in Newark and Trenton.[6] The former, designated the Essex Regional Office, provides representation at commitment hearings, periodic review hearings,[7] *habeas corpus* hearings, and individual cases involving conditions of treatment or confinement; the population served by this Office is comprised of all Essex County residents who are or may become institutionalized anywhere in the State, as well as the entire patient population at the Essex County Psychiatric Hospital in Cedar Grove. The Trenton office, denominated the Mercer Regional Office, provides the same four types of services to all residents of Mercer County facing institutionalization, including those residing at Trenton Psychiatric Hospital.[8]

(Footnote continued from preceding page)

> represent the interests of indigent mental hospital admittees in such disputes and litigation, as will, in the discretion of the Director . . . best advance the interests of indigent mental hospital admittees as a class on an issue of general application to them. . . . N.J.S.A. 52:27E-25.

For a discussion of the results of some of these class actions, see Perlin and Siggers, 4 *Bull. Am. Acad. Psych. & L., supra,* at 207.

[6] As indicated at footnote 4, *supra,* the Division is in the process of establishing a similar office in Camden County.

[7] On November 12, 1974, Chief Justice Richard J. Hughes of the New Jersey Supreme Court issued Memorandum #4-74 to all assignment judges, trial court administrators and county clerks, establishing among other procedures, a schedule of periodic reviews of "all persons who are now, or may hereafter become, involuntarily committed" in the State. The memorandum also mandated docketing and scheduling procedures for final commitment hearings which essentially presaged the current N.J. Ct. R. 4:74-7. The full text of the memorandum is set forth in the Appendix at 3a.

[8] The Mercer Regional Office has also assumed responsibility for providing representation to clients residing in Hunterdon County, a smaller area adjacent to Mercer County.

The regional offices are staffed by attorneys (three in Trenton, five in Newark) and "field representatives" (three in Trenton, five in Newark). This latter term denotes non-lawyer staff personnel who are, by virtue of background training and prior work experience, mental health professionals.[9] Although conceived of, by statute, as "law

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[9] The supervisor of all the field representatives in the Division, who works out of the Trenton office, holds a Doctorate in psychology and had more than five years of prior work experience in related mental health fields. In the Trenton office, the supervising field representative holds a Doctorate in Social Psychology, and has seven years of experience in mental health related fields prior to coming to the Division; another field representative holds a Masters degree in Social Work and a year of prior experience as a social worker; the third field representative holds an Associate of Arts degree and has had two years prior experience in mental health related areas.

The supervising field representative in the Newark office holds a Master of Arts degree and has completed two years of study toward his Doctorate in psychology. He worked for three years as a clinical psychologist prior to coming to the Division. Another field representative holds a Masters degree in Social Work and has had more than two years prior experience in mental health related areas. Two others hold Bachelor of Arts degrees and together have had more than four years of related work experience. One position is currently vacant.

The supervising field representative in the planned Camden office holds a Doctorate in Clinical Psychology and seven years of experience in mental health related fields; two other field representatives have Bachelor of Arts degrees and six years each of prior related experience. The fourth has completed three years work towards a Bachelor of Arts degree and had two years of related work experience.

In the class action office (Trenton), the supervising field representative holds a Masters degree in social work and had six years of prior related work experience. The second holds a Masters in Social Work and the third is a registered psychiatric nurse, who had eight years of prior related experience, including two years as a co-therapist for sex-offenders in the New Jersey prison system.

offices", the regional offices operate, in practical effect, as a partnership among all professionals on the staff. The ultimate service provided may be "legal" in nature (*i.e.* serving as counsel or, in the case of a juvenile, as guardian *ad litem* as well, at a legal proceeding such as a commitment hearing or a periodic review), but input into the final result comes from all staff members. The field representative interviews the patient/client initially[10] and gathers all data pertinent to the type of legal representation called for. In the case of a commitment hearing, the field representative will ascertain (1) the client's current medical/psychological condition as evidenced both by the hospital records and by the field representative's assessment of the client at the time of the interview; (2) the client's background—both social and medical—and current family situation; (3) the availability of alternative care facilities appropriate to the client's needs; (4) the need for recruiting independent psychiatric testimony to present on behalf of the client at the hearing. For periodic reviews, the field representative will obtain information pertinent to (1) through (4) above, and, in addition, will review

[10] In the case of a commitment hearing, where the client has been hospitalized under a temporary commitment order, under N.J.S.A. 30:4-37 and 30:4-38, the name is referred to the appropriate regional office by the Office of the County Adjuster in the county of the patient's residence. In the case of periodic reviews (see footnote 7, *supra*, at p. 6), the names of patients whose hearings have been scheduled are referred to the appropriate regional office by the Office of the County Clerk in the county of the patient's residence.

It should be noted that a bill before the State Legislature, S.1677, would totally revamp the involuntary civil commitment procedure, mandate the creation of county screening centers, and provide hearings for all patients within 72 hours of admission. The bill has passed the full State Senate as well as the Assembly Institutions, Health and Welfare Committee, and is now before the full Assembly.

the patient's history of hospitalization to evaluate the nature of the care and treatment rendered in an effort to determine if continued hospitalization is appropriate.

The field representative then confers and works closely with the attorney to develop the appropriate legal strategies in light of the individual patient/client's needs and desires. The attorney appears at the hearing as the patient/client's advocate, to advance that individual's desires to the maximum extent feasible, and to give the client a means of reaching outside the system for an examination of situations in which his rights as an individual citizen may have been violated. *Herr, supra,* at 11, citing Sen. Rept. 94-160, at p. 38. All final legal decisions concerning a given patient are thus bottomed on a joint effort by the several professions represented on the Division's staff.[11]

[11] The Division of Mental Health Advocacy thus provides representation in both individual and class matters in the systemic, organized way contemplated in and urged by the relevant scholarly literature. See, *e.g.*, Andalman and Chambers, "Effective Counsel for Persons Facing Civil Commitment: A Survey, Polemic and a Proposal," 45 *Miss. L.J.* 43, 75-76 (1974); Litwack, "The Role of Counsel in Civil Commitment Proceedings: Emerging Problems," 62 *Calif. L. Rev.* 816, 826, 839 (1974); Note, "The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill," 67 *Col. L. Rev.* 672, 689 (1967). For critiques of the role of the occasional or assigned counsel in such matters, see, *e.g.*, Cohen, "The Function of the Attorney and the Commitment of the Mentally Ill," 44 *Tex. L. Rev.* 424, 448, 450, 457-458 (1966); Weihofen, "Mental Health Services for the Poor," 54 *Calif. L. Rev.* 920, 939 (1966); "Developments in the Law—Civil Commitment of the Mentally Ill," 87 *Harv. L. Rev.* 1190, 1288 (1974) (hereinafter "Developments"); Comment, "Liberty and Required Mental Health Treatment," 114 *U. Pa. L. Rev.* 1067, 1068-1070 (1966).

B. Procedural rights for all individuals, including juveniles facing commitment to a mental institution, have been codified in N. J. Ct. R. 4:74-7.

Prior to September 8, 1975, New Jersey civil practice rules provided that a person facing civil commitment receive written notice of the time and place of the final hearing "at least *one day* before the date fixed." N.J. Ct. R. 4:74-7(e) (1969 rev.) (emphasis added). If the patient was not confined prior to the hearing, service was to be upon him or her personally or upon his or her attorney; if the patient was in an institution prior to the hearing, the county adjuster was required to effect personal service. The prior rules further provided that the "notice shall contain a statement that if the patient desires to oppose the application for a final judgment of commitment, he may appear personally or by attorney at the time and place fixed for the final hearing." *Id.* The decisions whether to hold an actual hearing and whether to have the patient present were completely discretionary with the court. N.J. Ct. R. 4:74-7(f) (1969 rev.).

However, following a trial court decision that a right to counsel attached to all commitment hearings, the State Supreme Court—faced with the contention that due process requirements under the Fourteenth Amendment to the United States Constitution and Art. I., Para. 1 of the New Jersey Constitution mandated the application of the full panoply of procedural due process guarantees in the involuntary civil commitment process[12]—both dismissed as moot a county's appeal from the lower court's ruling, and simultaneously promulgated revised N.J. Ct. R. 4:74-7

[12] The range of rights includes notice, hearing, right to be present, confrontation of witnesses, and, especially, the right to be represented by counsel.

(1975 rev.), mandating counsel at all such hearings, as well as at periodic reviews, and establishing a full range of due process safeguards at such hearings. *In re Geraghty*, 68 N.J. 209, 343 A. 2d 737 (1975). Subsequent to that 1975 revision of the rules, certain sections—specifically including several applying directly to juveniles—have been further amended, effective September, 1976.

The combined net effect of the current rule and pertinent statutes (N.J.S.A. 30:4-27 *et seq.*) is that civil commitment proceedings in New Jersey now involve, at the least, the following procedural provisions, as a matter of practice:[13]

(1) An order for temporary commitment must be based on an application supported by the type-

[13] Another challenge to the New Jersey civil commitment practice had been lodged in October 1973, in a federal court suit questioning the constitutionality of N.J.S.A. 30:4-37; 4-38; 4-41; and 4-42, as well as N.J. Ct. R. 4:74-7(b), (c), and (e) (1969 rev.). *Coll* v. *Hyland*, 411 F. Supp. 905 (D. N.J. 1976). The decision of the three-judge court in *Coll* was subsequent to the adoption of the 1975 revision of N.J. Ct. R. 4:74-7 and the decision in *In re Geraghty, supra.* Therefore, the Court weighed Coll's constitutional challenges in light of the new Rule and stated: "[W]e confine our inquiry to the constitutionality of the current rules of court, which are substantially different from those previously in effect." 411 F. Supp. at 907. The Court found the current New Jersey rule to provide constitutionally adequate procedural protections to persons facing involuntary civil commitment. Specifically, the Court rejected Coll's contention that a preliminary hearing was constitutionally required, citing the 20-day limit for final hearings in the New Jersey rule. The *Coll* Court went on to find that the procedures codified by the current New Jersey rule met constitutional muster. "After a thorough review of the New Jersey statutes and procedural rules governing civil commitments, we conclude that constitutional standards have been met. Accordingly, judgment will be entered in favor of the defendants." 411 F. Supp. at 913.

written or legibly hand printed certificates of two physicians licensed in any one of the United States, wherein each physician shall state the particular facts relied upon to support commitment;

(2) Such order must provide for a day and place certain on which the final commitment hearing is to be held, which shall be no more than 20 days from either the filing of the application, or the date of the temporary commitment order, or the date of admission of the client to the institution, as the case may be;[14]

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[14] N.J.S.A. 30:4-25 provides:

Classes of commitment

For the purpose of this Title the method of commitment of mentally ill patients shall be divided into 5 classes:

Class A. Where immediate temporary confinement in an institution is not necessary before making final order of commitment.

Class B. Where immediate temporary confinement is necessary, owing to the condition of the patient, and where an order of temporary confinement can be obtained before the patient is taken into such institution.

Class C. Where immediate confinement in an institution before making the temporary order hereinafter referred to is necessary, owing to the condition of the patient, and where an order of temporary commitment cannot be obtained before the patient is taken into such institution.

Class D. Where a person voluntarily applies for admission to an institution for treatment. In all such cases the admission and maintenance shall be governed by the provisions of section 30:4-46 of this Title.

(Footnote continued on following page)

(3) Counsel must be appointed, by the temporary commitment order, to unrepresented clients, and juveniles shall be assigned guardians *ad litem* who must be attorneys;

(4) Notice of the final hearing, which must be served *no less than* 10 days prior to such hearing, shall be personally served upon the patient, and shall also be served on the patient's counsel or guardian *ad litem*, the nearest relatives of the patient, the county adjuster and the superintendent of the institution where the patient is confined if such is the case;

(5) The patient, through counsel, has broad discovery rights, as well as the right to appointment of independent psychiatric experts without charge to the patients;[15]

(6) Oral testimony must be taken at the final commitment hearing from a licensed physician who has examined the patient since the date of the temporary order;

(Footnote continued from preceding page)

Class E. Where a person in confinement, under care of the chief executive officer of any correctional institution, is to be transferred to an institution for treatment. In all such cases the procedure shall be governed by the provisions of section 30:4-82 of this Title.

[15] This section of the rule, N.J. Ct. R. 4:74-7(d) (1976 rev.) incorporates the holdings of *Patients* v. *Kallen*, 123 N.J. Super. 175, 302 A. 2d 142 (App. Div. 1973); *In re Gannon*, 123 N.J. Super. 104, 301 A. 2d 493 (Somerset Cty. Ct. 1973), and *In re Alfred*, 137 N.J. Super. 20, 347 A. 2d 539 (App. Div. 1975).

(7) The patient must be present at the hearing unless good cause is shown for excluding him or her;

(8) A final order of commitment shall provide a schedule of periodic reviews to be conducted in the manner required for final commitment hearings;[16]

(9) If an order is entered at the final commitment hearing discharging a temporarily confined patient, such order may establish conditions for discharge such as attendance at a mental health care facility on an out-patient basis, *cf. State* v. *Carter,* 64 N.J. 382, 316 A. 2d 449 (1974).

Minors are afforded virtually the same procedural protection as adults in civil commitment proceedings irrespective of who makes the original application for the minor's commitment. Specifically with respect to juveniles, N.J. Ct. R. 4:74-7(j) (1976 rev.) provides:

> Institutionalization of Minors. A minor shall be institutionalized for the treatment of mental ill-

[16] The 1976 revised rules have changed the review schedule mandated for all confined patients. While adults are to be reviewed in a plenary-type hearing for the first time within three months from date of judgment, then again within six months from date of judgment and annually thereafter, minors' cases are required to be reviewed every three months until discharged or upon reaching majority. N.J. Ct. R. 4:74-7(f) (1976 rev.). Further, those patients whose condition is regarded as "irreversible," *i.e.,* suffering from either severe mental retardation or irreversible brain syndrome, are exempted from plenary review, provided notice of summary review is given to all interested parties—however, this exemption from plenary annual review does not commence until two years following the date of original judgment. *Id.*

> ness only upon court order entered in accordance with the procedures prescribed by paragraphs (b) through (g), inclusive, of this rule except that (1) Irrespective of whether or not he meets the standard of involuntary commitment stated by this rule, any minor 14 years of age or over may request his admission to an institution for psychiatric treatment provided the court on a finding that the minor's request is voluntary, enters an order approving the admission. If an order approving a voluntary admission of a minor is entered, the minor may discharge himself from the institution in the same manner as an adult who has voluntarily admitted himself. An order approving a voluntary admission shall be reviewable as provided by paragraph (f) of this rule, however, said review may be summary, and (2) This rule shall not be construed to require any court procedure or approval for the admission of a minor by his parent, parents, or other person in *loco parentis* to any institution for the evaluation or diagnosis of a mental condition provided the admission does not exceed seven days. If further hospitalization is then required, the applicant shall proceed in accordance with paragraph (e) of this rule. If an application for commitment is made during such admission, the final hearing shall be held within 20 days from such admission, adjournable only in accordance with subparagraph (e)(1) of this rule.[17]

[17] This provision of the rule differs substantially from the original 1975 revision which merely stated:

> Commitments of Minors. No minor shall be committed except temporarily to a mental institution for treatment and care

(Footnote continued on following page)

In addition, paragraph (b) of the rule specifically changes the standard of commitment for minors, as distinguished from the "probable danger to self or others" standard continued for adults. See N.J. Ct. R. 4:74-7(b) (1976 rev.):

> If the patient is a minor, the certificate may state, alternatively, the facts upon which the physician relies in concluding that the patient is in need of intensive psychiatric therapy which cannot practically or feasibly be rendered in the home or in the community or on any out-patient basis. *Id.*

The changes in the 1976 revision are thus fourfold: although the standard for commitment is now more "lenient" (*i.e.*, instead of the "probable danger to self or others" standards applicable to adults, juveniles may be committed also if found to be in need of intensive psychiatric therapy which cannot practically or feasibly be rendered in the home or in the community or on any out-patient basis), in at least three areas, juveniles are afforded additional procedural protections. Their commitments are periodically reviewed every three months from time of entry until the juvenile is either discharged or reaches majority, N.J. Ct. R. 4:74-7(f) (1976 rev.); the role of counsel is expanded to include the duties of guardian *ad litem*, N.J. Ct. R. 4:74-7(c)(2) (1976 rev.), which enables the attorney to employ all available resources—legal, medical and social, institutional and noninstitutional—to achieve a judicial result appropriate to the particular needs and wishes of the individual juveniles; further, special provisions are made for truly voluntary commitments whereby any minor 14 years of age or over may request his admission to an institution for psychiatric treatment, *provided* the court finds such a request is voluntary and enters an order approving such admission, N.J. Ct. R. 4:74-7(j)(1) (1976 rev.).[18]

(Footnote continued from preceding page)

> of an alleged mental condition on the application of his parent or other person in loco parentis except on court order after hearing pursuant to paragraph (e) herein. A guardian ad litem, who shall be a person other than the applicant for the commitment, shall be appointed by the court to represent the interests of the minor at such hearing.

N.J. Ct. R. 4:74-7(j) (1975 rev.).

Further, the 1976 amendment requires the guardian *ad litem* to be a person other than the applicant for the commitment. N.J. Ct. R. 4:74-7(c)(2) (1976 rev.). "This requirement is intended to provide the child with complete insulation in the legal sense from the applicant, who in most cases will be the parent or other person in *loco parentis.*" Pressler, *Current N.J. Court Rules*, Comment 4 to R. 4:74-7, at 829 (1976).

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[18] A minor committing himself voluntarily is, for discharge purposes, in the same category as adults who voluntarily commit themselves and, therefore, may, pursuant to the statute, discharge themselves on 72 hours' notice. See *In re Williams*, 140 N.J. Super. 495, 356 A. 2d 458 (Essex Cty. J.D.R. Ct. 1976).

C. In those juvenile commitment cases in which juveniles were represented by *amicus*, Department of the Public Advocate, Division of Mental Health Advocacy, there has been no evidence of exacerbation of familial situations; on the other hand, the dispositions bespeak individualized treatment by counsel and individualized determinations by the Court.

Since the promulgation of N.J. Ct. R. 4:74-7 (1975 rev.), field offices have undertaken to provide—in Mercer, Hunterdon and Essex counties—attorney and guardian *ad litem* services as required by N.J. Ct. R. 4:74-7(c)(2) and (j) (1975 rev.). This has involved the delivery of the four types of services discussed *supra* at pp. 8-9, but on a somewhat broader level than for adult clients. As will be discussed further below, the assignment of a guardian *ad litem* role to Division attorneys has placed these attorneys in a unique position *vis-a-vis* the court and the applicant for commitment. The role of counsel in juvenile commitment proceedings, as effectuated by Division attorneys, has taken on new dimensions of responsibility and authority.

As of August 1977, the two field offices combined represented approximately 213 juveniles since September 8, 1975 at civil commitment proceedings and at periodic review hearings. The vast majority of these clients have been between the ages of fifteen and seventeen, although the Division has represented children as young as seven years of age.[19]

In the 213 juvenile cases closed by the Mercer and Essex County field offices of *amicus* Department of the Pub-

[19] As of August 1, 1977, the precise breakdown in terms of age levels was as follows: age 7-1, age 8-10, age 9-4, age 11-8, age 12-10, age 13-10, age 14-12, age 15-40; age 16-49; age 17-37; unknown-7.

lic Advocate, Division of Mental Health Advocacy, since the September, 1975 revision to N.J. Ct. R. 4:74-7(j), the dispositions reveal a pattern of individualized court determinations.[20] In addition, the dispositions of the cases reveal that counsel—in New Jersey—fulfills those multiple functions urged by respected commentators. See, *e.g.*, Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions", 62 *Calif. L. Rev.* 840, 888-890 (1974) [hereinafter "Volunteering Children"] (discussed specifically at Point II, p. 32 *infra*); see also, Stone, *Mental Health and Law: A System in Transition* 59, 233-237 (1975)(hereinafter Stone I).

Thus, of the 213 closed files,[21] 34 of the juveniles were discharged following the involvement of *amicus* as counsel but prior to a formal hearing, 31 were released at such a hearing (in virtually all cases to their parents' or guardian's custody), 14 were "discharged pending placement,"[22] six were "discharged pending placement" to a facility administered by New Jersey's Division of Mental Retarda-

[20] All statistics are on file with *amicus* Department of the Public Advocate, Division of Mental Health Advocacy.

[21] In three cases the Division did not represent the juvenile because of lack of indigency, see, *e.g.*, N.J.S.A. 52:27E-26, 27, and, in one case, the juvenile eloped prior to the hearing.

[22] The phrase "discharge pending placement"—apparently unique to New Jersey practice—covers those cases in which orders are entered discharging patients subject to the availability of a suitable alternative care or aftercare facility. These orders are usually accompanied by retention of jurisdiction by the Court to insure that the placements are, indeed, made within the specific time limits contained in the order. *Cf. Dixon* v. *Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

tion,[23] 15 were "discharged pending placement," to a residential school,[24] one was "discharged pending placement" to a drug rehabilitation facility,[25] one was discharged to the custody of Division of Mental Retardation officials, four were discharged subject to certain conditions,[26] two were transferred to out-of-state hospitals,[27] three were ordered admitted to a special education program while institutionalized,[28] five were remanded to local jails or youth detention facilities to await trial on criminal offenses or hearings on juvenile delinquency petitions, or to a facility for "juveniles in need of supervision" [JINS"],[29] and one was discharged to a foster home. In addition, in two cases, adjournments were entered (so as to facilitate residential school placement and to avert the potentially stigmatic effect of a commitment label),[30] and in 38 cases, voluntary applications for admission were accepted.[31] Finally, in 22 cases commitment was ordered, and in 30 cases, confinement was continued.[32]

[23] See generally, N.J.S.A. 30:4-165.1 *et seq.*

[24] See generally, N.J.S.A. 18A:46-9, 13, 14, 15.

[25] See generally, N.J.S.A. 30:6C-5.

[26] *E.g.*, that the juvenile participate in a specific aftercare program.

[27] See generally, N.J.S.A. 30:7B-1 *et seq.*

[28] This, *e.g.*, requires the release of certain funds by the board of education in the municipality in which the juvenile resided. See generally, N.J.S.A. 18A:46-13, 14. *Cf.* 20 U.S.C.A. §1415 (effective October 1, 1977).

[29] See generally, N.J.S.A. 2A:4-45, 56, 57.

[30] See generally, "Volunteering Children," *supra,* at 845, 848.

These statistics reflect, then, individual determinations on individual bases. Dispositions are not limited to a finite commit/release paradigm (a fear often articulated by those who see the involuntary civil commitment process as taking on all of the trappings of the criminal trial);[33] on the other hand, they are specifically structured so that an individualized determination can be made—following the full participation of counsel at all relevant stages of the proceedings—in the manner contemplated by, *inter alia,* Ellis, Stone I and Cohen, all *supra.*

Significantly, in a lengthy and thoughtful analysis of this problem, Assistant United States Attorney John P. Pannenton has noted:

> Both the doctor and the minor's attorney should independently determine whether the child is being coerced into seeking psychiatric help. Then a search should be conducted to ascertain whether possible alternatives to institutionalization exist in the community. Outpatient treatment, special education programs, foster homes, and family counseling services, to name only a few, may further the child's interest far better than institutionalization. If the adult designated to represent the child finds

[31] See *In re Williams, supra;* N.J. Ct. R. 4:74-7(j) (1976 rev.).

[32] In two of the latter cases, special orders were entered ordering independent psychiatric evaluations of the juvenile. See, *e.g., In re Alfred, supra.*

[33] See, for such a view, Peszke, *Involuntary Treatment of the Mentally Ill* (1975).

> that his client wishes to contest the hospitalization, the role to be assumed by the adult is that of an adversary. As such, the skills of an attorney are required to prepare a proper defense and to obtain all relevant information which may prove beneficial to the child.

Pannenton, "Children, Commitment and Consent: A Constitutional Crisis," 10 *Fam. L. Q.* 295, 332 (1977) (hereinafter "Constitutional Crisis").

Indeed, the roles played by *amicus* in the cases in question have gone far beyond simple trial representation: in many of those cases in which *amicus* was appointed guardian *ad litem* as well as counsel,[34] orders were entered continuing the Division as guardian *ad litem* beyond the actual formal commitment (or acceptance of the voluntary application) so as to facilitate and insure the implemention of an aftercare plan. In other cases, *amicus* has played an active role in such areas as facilitation of school placement,[35] and unblocking of available funds for special educational programs, assisting the family in obtaining an appropriate community education program for the juvenile,[36] representing juveniles on individualized right to treatment,[37] or right to obtain Medicaid funds,[38] facili-

[34] See, N.J. Ct. R. 4:74-7(j).

[35] A corollary of such a role is, of course, its inverse: *amicus* also has acted to deter inappropriate placements.

[36] See generally, N.J.S.A. 18A:46-14.

[37] See, e.g., N.J.S.A. 30:4-24.1; *In re D.D.*, 118 N.J. Super. 1, 285 A. 2d 283 (App. Div. 1971).

[38] See generally, 42 U.S.C.A. §1396 *et seq.*

tation of an available family therapy program, provision of independent psychiatric expertise to the family so that the juvenile could readjust to his home setting after commitment,[39] resolution of conflicts between social service agencies (*e.g.*, Division of Youth and Family Services [DYFS]) and the juvenile's family, and finding suitable aftercare or alternative care placements. These various functions again, reflect a "counseling attitude" that far transcends the narrow range of choices often feared as a necessary concomitant to the presence of adversarial counsel.

In addition, it appears that—in most cases—parents were affirmatively pleased with the involvement of *amicus*. Although parents were hostile to the role of adversary counsel in a handful of cases, in the vast majority, parents were described by *amicus* counsel as "enthusiastic about our involvement," "thankful for involvement," "receptive," "cooperative," "positive," "helpful," "pleased," "grateful," "very involved," "appreciative," "supportive," and "interested and informative."

Interestingly, in at least four cases, parents who began with "negative" feelings or who were "uncooperative" with counsel, radically changed their attitudes during the course of representation and became "positive" or "cooperative" by the time of the final hearing.[40] In these

[39] In this case, following acceptance of the juvenile's own voluntary application, he was subsequently discharged and is now receiving out-patient treatment at home.

[40] As part of the preparation of this brief, the Mercer and Essex Regional Offices of the Division of Mental Health Advocacy were asked for statistical read-outs on their respective juvenile cases. One statistical category asked for "response of family" (to legal representation of the juvenile by Division attorneys), in response to which subjective answers such as those appearing in the text were received.

cases, it is most clear that counsel did not exacerbate tension; rather its presence actually served to alleviate such feelings and strengthen interfamilial bonds.[41]

Thus, it has been suggested that, "in a crisis situation, parents may go to the first facility about which they are told or to whatever facility is closest[,] . . . see[ing] hospital care as the only approach to the crisis." Note, "'Voluntary' Admission of Children to Mental Hospitals: A Conflict of Interest Between Parent and Child," 36 *Md. L. Rev.* 153, 160 (1976) [hereinafter "Conflict of Interest"]. The presence of outside counsel serves to help insure that this parental decision—often premised on incomplete or inaccurate information—is not made and ratified in a factual vacuum.[42] Similarly, it has been noted that, "[E]ven with benevolent motives, parents may in fact be acting adversely to the child's welfare." "Constitutional Crisis," *supra*, at 318. A newsletter published by the U.S. Department of Health, Education and Welfare points this out graphically:

[41] Another phenomenon worth noting is that, in those cases in which counsel either represented the juvenile on treatment questions or actively sought an after-care or out-patient program, in virtually all instances, parents were especially positive about Division of Mental Health Advocacy involvement. Thus, one casenote indicates, "Mother attended hearing; appreciates 'pushing' by DMHA [Division of Mental Health Advocacy] for placement" (client placed in appropriate facility for juveniles with learning disabilities); in another, where a juvenile was discharged to the custody of a "JINS" program administrator, the note reads, "Father interested: pleased with final disposition; participated in decision."

[42] The same author points out that this is especially a problem in families of lower socioeconomic status: "For poor families, dependent upon public institutions, their problem is compounded by a more limited number of resources from which to choose." *Id.*

> A small but steady stream of letters continues to flow in from parents whose children are in institutions for the retarded or mentally ill or who are contemplating commitment . . . it seems safe to say that most decisions to commit to a large institution are made only because no other choices are available. When parents are obliged to keep their children at home 24 hours a day, seven days a week because no education nor treatment programs will accept him, they are usually desperate for relief from an impossible burden of care. When they "choose" to place their child in an institution where conditions will work against the child rather than for him it is only because no other public alternatives are available . . .

Id. at 318-319, n.101, citing "Close Look Newsletter," (Special Information Center 1972).

Finally, the presence of counsel has led to exceptional judicial creativity in an area in which, most likely, such creativity would be conspicuously absent but for the presence of an adversarial role. In *In re Pamela T.*, Docket No. ESCC 16-68 (Essex Cty. J.D.R.Ct. 1975), a "treatment program" mainly consisting of over 200 electroshock applications and 23 hours a day in seclusion—structured in response to the "behavior problems" of a young girl with an organic brain condition—was struck down as violative of the Eighth Amendment's ban on cruel and unusual punishment;[43] in *In re Williams, supra,* the court

[43] *Cf. Rozecki* v. *Gaughan,* 459 F. 2d 6, 7 (1 Cir. 1972). The *Pamela T.* case received widespread press attention following entry of the court order. See *e.g.,* Jaffe, "Horror Story at Greystone Ends for Girl," *Newark Star-Ledger,* Vol. 62, No. 79, p. 1, col. 7 (May 12, 1975). All orders in juvenile commitment cases are on file with the Division of Mental Health Advocacy.

held that a juvenile—on his own—could voluntarily admit himself to an institution (thus avoiding the stigma inherent in an involutary commitment) if he "understood the nature of a voluntary commitment and grasped the significance of the . . . proceedings"; in *In re D.G.*, Docket No. HNCC 1-76 (Hunterdon Cty. Ct. 1976), the court held that all documents and records pertaining to the involuntary commitment proceedings be impounded "to protect the interests of the juvenile.[44] In *In re G.G.*, Docket No. MECC 164-75 (Mercer Cty. Ct. 1975), in which *amicus* represented a juvenile whose condition had been gravely deteriorating and on whom psychotropic medication was having no positive effect, and where both the juvenile's independent psychiatric expert witness and the hospital physician advocated the use of electroshock, *amicus* petitioned the court to determine the need for such treatment.[45] Following the hearing, the treatment was ordered

[44] This practice has been subsequently adhered to in all juvenile commitment matters.

[45] In a letter to the Court, the attorney arguing the case stated:

> In the case at hand, I believe it should be the role of counsel not to blindly resist treatment, but to assist the court in monitoring the decision process of the medical professionals. To this end, I intend to elicit testimony at the forthcoming hearing regarding the availability of alternatives to electric shock therapy, the risks associated with its use, and the chances for negative results in addition to testimony supporting the use, so that a detailed background will exist upon which the Court may render its decision.

Letter from Herbert D. Hinkle, Esq., counsel for juvenile, to Honorable George Y. Schoch, Assignment Judge, Superior Court, Law Division, Mercer County, N.J., November 26, 1975, in *In re G.G.*, *supra*.

and administered, and the juvenile has been subsequently discharged.[46]

In the case of a nine-year old autistic child, *amicus* successfully petitioned the court to prohibit the use of aversive, electro-prod therapy, unless rigorous standards for staff training and program management were met, *In re C.B.*, Docket No. MECC 8202 (Mercer Cty. Ct. 1976). As the hospital did not comply with the court-ordered conditions, a previously entered order mandating such "treatment" was subsequently vacated.[47]

In *In re M.V.R.*, Docket No. MECC 251-76 (Mercer Cty. Ct. 1976), the court ordered a local school board to reconvene from recess so as to immediately appropriate funds (the release of which would be otherwise blocked due to the recess) to provide specialized treatment for the juvenile in question.[48] In a case where the court had ordered a mentally retarded minor transferred from the state hos-

[46] This case is described in greater detail in Perlin, "The Right to Refuse Treatment in New Jersey," 6 *Psychiatric Annals* 300, 304 (1976).

[47] The Division is presently seeking placement for this child in a special residential school in Rhode Island which can provide trained experts to deal with the minor's particular illness. An earlier phase of the case is noted at Perlin and Siggers, 4 *Bull. Am. Acad. Psych. & L.*, *supra*, at 212, n.37.

[48] In another school funding case, where treatment had been delayed due to a refusal of several school boards to assume funding responsibility (due to frequent changes in domicile by the juvenile's family), the court ordered all of the boards to resolve the financial dispute, and ordered the juvenile discharged from the state hospital to an appropriate residential school with full funding. *In re J.M.*, Docket No. MECC 217-76 (Mercer Cty. Ct. 1976). *Cf. Bd. of Ed., Tp. of Little Egg Harbor* v. *Bds. of Ed. of Galloway Tp., et als.*, 71 N.J. 537, 366 A. 2d 977 (1976).

pital to a highly structured residential school (in a situation in which there was a sharp conflict among several interested relatives as well as between the relatives and the child herself), the court subsequently ordered that the juvenile be permitted trial home visits with different relatives (specifically prohibiting the use of any coercion or force by the relatives in attempting to overbear the girl's will regarding ultimate placement) and—in accordance with the girl's wishes—specifically prohibited outright discharge to her relatives prior to treatment at the residential school and prior to a reevaluation of the child's own final wishes as to placement. *In re T.W.*, Docket No. MECC 150-77 (Mercer Cty. Ct. 1977).

Finally, in a case where DYFS had begun to initiate custody proceedings so as to place a borderline mentally retarded child in a foster home, the court accepted the suggestion of *amicus* counsel to adopt the position of the child's treating physician at a child treatment center that the child remain with his parents after treatment to minimize the possibility of psychological regression likely to occur if he were to be removed to a foster home setting. *In re R.Z.*, Docket No. MECC 103-76 (Mercer Cty. Ct. 1977).

Cases such as these reflect the end results of the presence of counsel: the presentation to the courts of individual cases in a manner susceptible to individualized creative determinations. Clearly, fears as to the involvement of counsel appear groundless. A system which affords counsel and other procedural protections to juveniles facing commitment is eminently workable.

II. There is no indication that the presence of procedural due process safeguards is detrimental to juveniles; rather, the evidence is persuasive that such safeguards are beneficial to all parties involved in juvenile commitment matters.

Appellants argue, variously, that a "medically-indicated decision [made by a parent] for his child . . . has always . . . been considered to be . . . well within [the] . . . parameters [of the parent's responsibility and authority]," Ab at 15, that there is "little evidence in the record that psychiatry is an 'exact science,'" Ab at 18, that the "principals, *irrespective of how the case is styled,* are parents and their children," Ab at 30 (emphasis added), that "the system created by the Georgia Code for the voluntary hospitalization of mentally ill children works, and works well," Ab at 38, and that "additional or more formalized procedures are unnecessary, and . . . may be harmful and detrimental to the children," *id.*, noting specifically that "it is doubtful that a lawyer on cross-examination could get any more beneficial information than could a psychiatrist," Ab at 39.[49]

It is suggested that all of these arguments fall wide of the mark, and that both the empirical and scholarly literature effectively rebut each of these statements. In fact, it is likely that the absolute inverse of each of appellants' assertions is the more accurate assessment of the

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[49] Appellants specifically quote from the testimony of Dr. John Filley, one of their witnesses, as to the potentially disruptive effect of such hearings:

> Due process proceedings in the court, witnesses, and so on are . . . alien in a child's life and airs all the dirty linen, not all of it probably, but it airs a significant amount of dirty linen in the child's life and parents' lives. Ab at 40.

situation, and that the evidence is persuasive that due process safeguards benefit all parties—the juvenile, the parents, the relevant social service agencies and service providers, and the state—involved in juvenile commitment matters.

At the outset, it is by no means clear that the decision to commit a juvenile—possibly against that juvenile's will—is "well within [the] . . . parameters [of the parents' responsibility and authority]."[50] Speaking of custody and divorce proceedings, Anna Freud, Joseph Goldstein and Joseph Solnit argue forcefully that the presumption that a child's parents are "generally best suited to represent and safeguard his interests . . . should not prevail [where neither parents nor the State] . . . have a conflict-free interest in representing the child." Goldstein, Freud and Solnit, *Beyond the Best Interests of the Child* 65-66 (1973). In such cases it is "crucial [to make] . . . adequate provision for [the child's] . . . personal representation by counsel who has no other goal than to determine what is the least detrimental alternative for his client." *Id.* at 66. See also, Kleinfield, "The Balance of Power Among Infants, Their Parents, and the State,"

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[50] It should be noted that the familial situations of the named plaintiffs *sub judice* greatly diverge from the harmonious, unified relationship feared by appellants to be endangered by the introduction of counsel and other due process safeguards for the minor. J.R., removed from his natural mother by the State at three months of age, experienced no stable familial relationship during his frequently changed foster home stays; J.L., adopted at eight hours old, has seen neither his adoptive parents nor stepfather since April, 1974, when he was "voluntarily" committed to the State hospital. Their situations indicate the fallacy in appellants' arguments: in the very cases that were the original subject matter of this action, "parental responsibility and authority" had been either previously abdicated or was nonexistent.

Part I, 4 *Fam. L.Q.* 320, 323, 324 (1970) ("[W]ithout counsel, rights [of children] not only fail to be vindicated; they fail also to be created"); Note, "On the Voluntary Admission of Minors," 8 *Mich. J. L. Reform* 189, 213-214 (1974) ("In almost any context in which the status, position, or future placement of a minor is involved, the minor should be provided with counsel. It is simply unrealistic for another party to an action, who had his own interests with which to be concerned, to be expected to adequately safeguard those of a minor involved in the matter").[51]

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[51] Accord, Kleinfield, 4 *Fam. L.Q., supra,* at 347; Katz, "Children, Privacy and Nontherapeutic Experimentation," 45 *Am. J. Orthopsychiat.* 803, 807 (1975); Knitzer, "Child Advocacy: A Perspective," 46 *Am. J. Orthopsychiat.* 200 (1976).

This Court has articulated this argument in a similar context in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976), in striking down a Missouri statute which had required parental or other guardian consent to most first trimester abortions if the woman involved was under 18 and married. Although the Court noted that the Federal District Court had suggested there was a significant state interest in the safeguarding of the family unit and of parental authority, 392 F. Supp. 1362, 1370 (E.D. Mo. 1975), it rejected this as an across-the-board rule:

> It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to stregthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.

(Footnote continued on following page)

In fact, an approach contrary to that suggested by appellants appears to better comport with the reality of contemporary society: "With the increasing tendency of society to recognize and uphold individual interests, a unitary concept of protection could not be expected to protect adequately the interests of parent and child where those interests diverge." Wilkens, "Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors," 31 *Ariz. St. L.J.* 31, 69-70 (1975) (hereinafter "Removing the Barrier") (footnote omitted).[52]

Thus, in his seminal article on the right of children to independent counsel prior to "voluntary" civil commitment, Mental Health Law Project staff attorney James Ellis reviews the development of due process safeguards at juvenile delinquency proceedings and at involuntary civil commitment matters, notes the "negligible role" currently played by counsel in the juvenile commitment process, "Volunteering Children," *supra,* at 881, and sketches the multiple roles that independent counsel should have at such a hearing, including *inter alia,* ascertaining the juvenile's true wishes, explaining possible outcomes to the client (including, specifically, potential restrictivity of setting, alternative treatment modalities, facility regulations, etc.), counseling the client on consequences of hospitalization, and "present[ing] . . . [the client's] wishes in as effective a manner as possible." *Id.* at 888-889. He adds further:

(Footnote continued from preceding page)

428 U.S. at 75. *Cf. In re Smith,* 16 Md. App. 209, 295 A. 2d 283 (Ct. Spec. App. 1972) (mother could not force teenage daughter to have an abortion under applicable state law).

[52] The same author underscores that "the power of decision over one's own physical integrity certainly is not a fundamental element in the family unit." *Id.* at 70.

> Finally, while the lawyer should try to avoid becoming a middle person in future power struggles between the client and the hospital (or parents) because of the detrimental impact that might have on the client's acceptance of ordered treatment, it is appropriate for the attorney to reassure the client that counsel will again be available at the time of the periodic review of commitment, and may also be available if problems arise concerning in-hospital civil liberties. The knowledge that there is someone on the "outside" who is concerned about his or her fate after hospitalization may be one of the most valuable things a lawyer can give to a child-client.

Id. at 890 (footnote omitted).[53]

Again it should be emphasized that:

> Recognition of minors' rights of self-determination will not contribute to the dissolution or func-

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[53] Stone I, *supra,* at 59, makes appoving reference to a similar list of attorney functions prepared by Cohen, 44 *Tex. L. Rev., supra,* similar to the ones suggested by Ellis, and notes:

> Surely, some of the aforementioned functions are social service roles which far transcend what has traditionally been viewed as the attorney's function, but if the attorney does not fill some of these needs, it is unlikely that anyone else will; and without aid of counsel, commitment can easily become a summary or self-fulfilling process. There are, increasingly, lawyers who understand and are willing to fill these needs. And if counsel come to be perceived as co-workers in the mental health system, dedicated to the aforementioned array of purposes, and not merely as righteously contentious obstructors, their presence during the commitment process will be welcomed rather than dreaded.

See also, Stone I, *supra,* at 233-237.

> tional breakdown of the family unit merely because the sometimes divergent interests of parents and children create a conflict in the parental consent doctrine, a doctrine formulated for the protection of both these interests. Role differentiation . . . should not be taken necessarily as a sign that the family unit is disintegrating.

"Removing the Barrier," *supra* (footnote omitted). It is suggested that this argument of appellants is without merit.

Similarly, appellants' suggestion that there is "little evidence" as to the inexactitude of psychiatric diagnosis and inaccuracy of psychiatric predictions is, simply, inaccurate. In fact, the evidence is, on the other hand, overwhelming that psychiatrists are no more significantly predictively accurate than non-psychiatrists (*e.g.*, lawyers). See Rappeport, Lassen, and Gruenwald, "Evaluation and Follow-up of Hospital Patients who had Sanity Hearings," in Rappeport ed., *Clinical Evaluation of the Dangerousness of the Mentally Ill* 89 (1969) ("The comparison between court released and hospital released adjustment rates shows no significant difference in the predictive accuracy of either institution"), and Ennis and Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," 62 *Calif. L. Rev.* 693, 749 (1974) (no evidence found that a physchiatrist can predict dangerousness more accurately than a lawyer). In fact, a recent report prepared by the American Psychiatric Association concludes that "neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness.'" American Psychiatric Association, *Clinical Aspects of the Violent*

Individual 28 (1975).[54] It would appear, thus, that appellants' argument on this point similarly is not supported by the relevant data.

Further, it appears that the participants in cases of this sort cannot be styled into the simplistic parent/child dyad suggested by appellants. This is especially so in light of the evidence which suggests that, in many in-

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[54] Of course, in the famous study of the so-called "Baxstrom patients" (those persons ordered released from New York's maximum security facilities for "insane criminals" following this Court's decision in *Baxstrom* v. *Herold*, 383 U.S. 107 (1966)), it was found that, of the 969 *Baxstrom* patients who had previously been statutorily incarcerated in maximum security facilities, within one year, only *seven* were recommitted to such a facility on a finding of dangerousness (although it had been predicted by hospital officials that nearly 250 would need that type security), and, of the 147 patients released to the community, only one had been arrested within that time period (for petty larceny). Hunt and Wiley, "Operation *Baxstrom* After One Year," 124 *Am. J. Psychiat.* 124 (1968), reprinted in Association of the Bar of the City of New York, *Mental Illness, Due Process and the Criminal Defendant* 224 (1968). The *Baxstrom* patients have received special behavioral scrutiny. See, *e.g.*, Steadman, "Follow-up on Baxstrom Patients Returned to Hospitals for the Criminally Insane," 130 *Am. J. Psychiat.* 317 (1973); Steadman and Cocozza, *Careers of the Criminally Insane* (1974). For a more recent evaluation and survey of the relevant literature, see Steadman and Cocozza, "We Can't Predict Who Is Dangerous," *Psychology Today* 32 (January 1975). See also, *e.g.*, Dershowitz, "The Law of Dangerousness: Some Fictions About Predictions," 23 *J. Legal Ed.* 24 (1971); Steadman, "Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychiatry," 1 *J. Psych. & L.* 409 (1973); Wenk, Robison and Smith, "Can Violence Be Predicted?" 18 *Crime & Delinq.* 393 (1972); Kozol, Boucher, and Garofola, "The Diagnosis and Treatment of Dangerousness," 18 *Crime & Delinq.* 371 (1972); Dershowitz, "Dangerousness as a Criterion for Confinement," 2 *Bull. Am. Acad. Psych. & L.* 172 (1974).

stances, the decision to institutionalize a child is quickly followed by abandonment on the part of the parents, and that there are negative effects associated with institutionalization which are antithetical to any theory of well-functioning family development.

While recognizing the tremendous importance of a minor's having a stable, functioning relationship with parents, Pannenton warns of the devastation a minor would suffer if he were to be faced with a situation in which the controlling adult in his life were unable to provide this needed strength and in which he would be simultaneously deprived of independent, objective counsel to safeguard his rights:

> It is clear that a child who is confined to a mental hospital receives none of the benefits of developing in a healthy family environment. Instead, the child is isolated from his family both physically and psychologically and is forced to substitute hospital personnel and other patients for his basic emotional needs. The process of child development remains partially a mystery, but it is accepted by most experts that the one factor necessary for healthy development is a reasonable continuity with parental figures. Therefore, children are more frequently best served by remaining in their natural homes whenever possible. Even with this principle in mind, it should be recognized that there are times when the family neither can be nor wants to be so effective. In these instances, an innocent child should not be made to suffer as a result of the family's limitations, but instead should be afforded individual rights for his own protection.

"Constitutional Crisis," *supra,* at 329 (footnote omitted).

An alarming illustration of the feared abandonment of children devoid of any objective legal guardian is starkly presented by a follow-up study involving the plaintiffs in *New York State Association for Retarded Children* v. *Rockefeller,* 357 F. Supp. 752 (E.D.N.Y. 1973) [hereinafter *NYSARC I*], supplemented *sub nom. New York State Association for Retarded Children* v. *Carey,* 393 F. Supp. 715 (E.D.N.Y. 1975). In that study, it was found that during the course of litigation approximately ten percent of the parents of those minors involved in the case had either relocated, failing to leave a forwarding address, or had refused to respond to inquiries directed to them, and thus, could not be found. Either possibility points to an objective lack of concern shown by a significant number of parents for their mentally retarded children.[55] See Post-Trial Reply Memorandum for Plaintiffs at 3, *NYSARC I, supra,* as cited in Note, "Civil Rights—Right to Treatment—Neither Due Process nor Equal Protection Clause of the Fourteenth Amendment Guarantees the 'Right to Treatment' for Mentally Retarded Children Confined in a State Institution Through Noncriminal Procedures," 2 *Fordham Urban L.J.* 363, 367 (1973).

Significantly, numerous authorities have warned that "the negative, antitherapeutic effects of institutionalization often counteract processes of natural or induced remission in mental dysfunction, thus producing more psychologic harm than good," Saphire, "The Civilly-Committed Public Mental Patient and the Right to Aftercare," 4 *Fla. St. U.L. Rev.* 232, 247 (1976). A phenomenon,

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[55] As there were some 5700 residents of Willowbrook at the time of the litigation, 357 F. Supp. at 755, nearly 600 parents, thus, had chosen to absent themselves from their children's lives.

termed "iatrogenic illness"—the intensification of illness caused by the *fact* of hospitalization itself—can thus result from a prolonged stay in a mental institution. Yolles, "Mental Health's Homeostatic State: A New Territory," 7 *Int. J. Psych.* 327, 328 (1969); Kantor and Gellineau, "Making Chronic Schizophrenics," 53 *Mental Hygiene* 54 (1969).

Other authorities have stated that the need to institute guaranteed independent counsel for minors is of paramount importance. Each delay in granting minors such safeguards may be critical to the well-being of countless children:[56]

> We cannot continue to risk the emotional, psychological and physical well-being of children and young adults at the price of parental consent. In such sensitive areas as birth control, pregnancy, drug abuse and emotional problems, seeking parent-

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[56] The cause for alarm is not unfounded. Ellis suggests that parents in recent years have resorted to "voluntary" commitment in reaction to the counter-cultural values and lifestyle they saw their children embracing. The parents' own visceral reactions thus motivated their decision in many instances. "Volunteering Children," *supra,* at 851. In addition, of course, societal pressures and personal feelings may also interfere with parental ability to decide upon the appropriate course of conduct:

> The parent may be motivated to ask for such institutionalization for a variety of reasons other than the best interests of the child himself, *i.e.,* the interests of other children in the family, mental and physical frustration, economic stress, hostility toward the child stemming from the added pressures of caring for him, and perceived stigma of mental retardation.

"Conflict of Interest," *supra,* at 169, n.80, citing Murdock, "Civil Rights of the Mentally Retarded—Some Critical Issues," 7 *Fam. L.Q.* 1, 10 (1973).

> al consent may be particularly counter-productive. Marker and Friedman, "Rethinking Children's Rights," *Children Today,* 74-14 DHEW Pub. No. (Nov.-Dec. 1973).

Again, it appears that appellants' position is unpersuasive.

Appellants argue further that the Georgia system "works and works well." Unfortunately, they cite absolutely no empirical evidence to support this allegation. In reality, it is likely that, without the provision of counsel, if the system "works," it can "work" only to the detriment of the juveniles involved. As will be discussed below, see pp. 41-42 *infra,* counsel plays a significant, even dispositive role, in commitment proceedings. It strains credulity to suggest that a system which does not provide this basic right—accurately characterized by this Court as one of those "immutable principles of justice which inhere in the very idea of free government," *Powell* v. *Alabama,* 287 U.S. 45, 71 (1932), quoting *Holden* v. *Hardy,* 169 U.S. 366, 389 (1898),—"works and works well." *Cf. State ex rel. Memmel* v. *Mundy,* 75 Wis. 2d 276, 249 N.W. 2d 573 (Sup. Ct. 1977) (upholding trial court order appointing legal aid society to represent *all* indigent patients in civil commitment proceedings).

Significantly, in its decision two years ago in *O'Connor* v. *Donaldson,* 422 U.S. 563 (1975), this Court characterized a similar argument as "unpersuasive," adding:

> Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present. *Id.* at 574, n.10.

Indeed, as Federal Judge David Bazelon has pointed out:

> When the limited function of a judge in reviewing administrative determinations is borne in mind, there seems little to distinguish psychiatry from, say, radio broadcasting. No judge would claim the ability to provide a particular therapy for a "chronic undifferentiated schizophrenic." But neither would any judge allocate frequencies to avoid interference. That is not his task in any case; his role rather is to determine whether a capable expert has studied the problem fully and reached a defensible result.

Bazelon, "Implementing the Right to Treatment," 36 *U. Chi. L. Rev.* 742, 745 (1969).[57] There is no evidence that the Georgia "model'" meets Judge Bazelon's well-articulated standards.

Finally, appellant argues that due process procedures are "unnecessary" and potentially "harmful and detrimental" to juveniles. This position, it is submitted, flies

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[57] Judge Bazelon has also dryly commented:

> . . . Diffidence in the face of scientific expertise is conduct unbecoming a court. Very few judges are psychiatrists. But equally few are economists, aeronautical engineres, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed dam on fish life, while they reject a similar scrutiny on the effect of psychiatric treatment on human lives . . . It can hardly be said that we are more concerned for the salmon than the schizophrenic.

Id. at 743; see also, Bazelon, "Psychiatrists and the Adversary Process," *Scientific Am.*, Vol. 230, No. 6 (June 1974), at 18, 23.

squarely in the face of the entire history of procedural due process jurisprudence in this country.

It is clear that counsel plays a critical, and in some cases, nearly dispositive role in involuntary commitment proceedings—where active attorneys are employed, fewer persons are committed, "Developments," *supra,* at 1285; Wenger and Fletcher, "The Effect of Legal Counsel on Admissions to a State Mental Hospital. A Confrontation of Professions," 10 *J. Health & Soc. Behavior* 66, 69 (1969) (74% of represented persons studied were released; only 9% of those not represented discharged); Kumasaka and Stokes, "Involuntary Hospitalization: Opinions and Attitudes of Psychiatrists and Lawyers," 13 *Comprehensive Psych.* 201 (1972); Kramer, "Protective Legal Services for the Mentally Ill," 23 *Hosp. & Commun. Psych.* 41, 42 (1972) (study of Mental Health Information Service in New York revealed 40.4% of all patients requesting hearings through counsel released by hospital psychiatrists prior to hearing), and that "intervention by counsel acting as patient's attorney tremendously increases chances of discharge, not to mention the other alternatives to hospitalization that may also be worked out to the patient's satisfaction," Gupta, "New York's Mental Health Information Service: An Experiment in Due Process," 25 *Rutgers L. Rev.* 405, 438 (1971). See also, Silverberg, "The Civil Commitment Process: Basic Considerations," in 1 *Legal Rights of the Mentally Handicapped* 103, 109 (Ennis and Friedman eds. 1973).[58]

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[58] Significantly, this conclusion was adopted in *Lessard* v. *Schmidt,* 349 F. Supp. 1078, 1099 (E.D. Wis. 1972), vacated on other procedural grounds 414 U.S. 473 (1974), on remand 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded on other grounds 421 U.S.

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Specifically, *amicus'* experience in New Jersey similarly reveals that Division attorneys were "successful"[59] in nearly three out of every four individual representations: these statistics merely further corroborate those studies

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957 (1975), reinstated 413 F. Supp. 1318 (E.D. Wis. 1976), as evidence that the traditional guardianship appointment does not satisfy constitutional requirements for counsel as it is not sufficiently an advocacy role. See also, Dix, "Hospitalization of the Mentally Ill in Wisconsin: A Need for Reexamination," 51 *Marq. L. Rev.* 1, 33 (1967); *Quesnell* v. *State,* 83 Wash. 2d 224, 517 P. 2d 568, 576 (Sup. Ct. 1974) (citing *Lessard* with approval).

See Epstein and Lowinger, "Do Mental Patients Want Legal Counsel? A Survey," 45 *Am. J. Orthopsychiat.* 88, 91-92 (1975) (majority of patients studied indicated need for legal aid in both court-related hospitalization proceedings as well as in non-hospital-related matters). The authors note that the effects of legal aid would include a diminution of the numbers of persons involuntarily committed, heightened efficiency of hospital operations (counsel serving as an effective check to insure the presence of therapy), and a change in the image of the hospital as a "total institution." Significantly, the authors point out that the process of conducting the survey was "not traumatic to either the patient or the institution." See also Steadman, *A Program for Mental Health Advocacy Services for Pennsylvania: The Independent Evaluation of the American Bar Association's Pilot Project* 22 (1977) [hereinafter Steadman I] (70% of patients surveyed indicated they would seek further advocacy assistance.

[59] The word "successful," simply, means the attainment of a client's objective. Usually this will refer to cases in which patients are released from a psychiatric hospital, transferred to a less restrictive environment, alternative or institution, or where a treatment objective is obtained.

cited, *supra.*[60] It should also be noted that, through the intervention of *amicus* as counsel, juveniles in New Jersey are able to truly voluntarily admit themselves to institutions, thus, avoiding the stigma of commitment if they understand "the nature of a voluntary commitment and grasp . . . the significance of the proceedings," *In re Williams, supra;* this effectively rebuts appellants'

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[60] Illustratively, in the 5281 cases closed by the Mercer and Essex Field offices from the time of the Division's creation in the summer of 1974 until July 1, 1976, of the 4330 cases litigated beyond the referral stage, the Division obtained relief for 3140 clients (73%).

Thus, excluding those 755 cases in which clients were advised and assisted or referred to other agencies, the Division prevailed in 2783 of 3557 (78%) litigated nonperiodic review cases (including civil commitment, *habeas corpus* and individual treatment matters). These included 1576 cases in which clients were released to the community prior to a hearing, 419 in which they were transferred to less restrictive institutions, environments or conditions, 726 in which a *habeas corpus* petition was granted, or commitment was denied, and 27 in which a right to treatment/patients' rights petition was granted. In five cases, treatment claims were denied, and in 771 cases, either *habeas corpus* was denied or commitment was ordered.

Again, after excluding those 73 cases in which clients were advised and assisted or referred, the Division was successful in 346 of 762 (45%) litigated periodic review matters. In the 346 cases, clients were either released to the community or transferred to a nursing home, health care service facility, or other less restrictive facility, while in 416 cases commitment was continued.

Finally, the Division was successful in 11 of 11 (100%) litigated cases brought pursuant to *State* v. *Krol,* 68 N.J. 236, 344 A. 2d 289 (1975), governing commitment and review proceedings for persons found "not guilty by reason of insanity" under N.J.S.A. 2A:163-3.

All statistics are on file with the Division. See generally, Department of the Public Advocate, "Second Quarter Report" (1977), at 7, 11; for an earlier statistical overview, see Perlin and Siggers, 4 *Bull. Am. Acad. Psych. & L. supra,* at 211-212, n.30.

contention that the importance of procedural due process would "forc[e] [a child] to engage in an adversarial hearing irrespective of whether he desires to do so." Ab at 41.

Importantly, Dr. Eli Charles Messinger, an expert witness for the juveniles in the District Court in this matter, points out several ways in which the family would benefit from the provisions of due process protection for the child. All parties would have an opportunity to air their differences in an open and forthright manner:

> Rather than masking family disputes and difficulties, they would be recognized so they could be dealt with more constructively. Emphasis would be placed on developing a comprehensive picture of the events that have led parents to seek institutionalization of the juvenile. This effort at fact finding in itself would have a therapeutic effect on the child and family; for some it would be the first time that they will have been exposed to all sides of the story.

"Conflict of Interest," *supra,* at 173.

He also sees counsel, in addition to actually aiding a family in conflict by providing the objective negotiating tools of the law and due process, as providing a specific service needed by hospital staffs yet otherwise largely unavailable:[61]

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[61] The often disinterested role of counsel who represent psychiatric facilities is well-documented. See *O'Connor,* 422 U.S. *supra,* at 578, n.1 (Burger, C.J., concurring) ("[On remand], I would hope these sensitive and important issues would have the benefit of more effective presentation and articulation on behalf of petitioner"). See also, Stone, "Treatment Rights and Civil Liberties," in American Bar Association, *National Conference on the Legal Rights of the Mentally Disabled* 1, 10 (1976) ("Judging from the quality of the briefs [on behalf of defendant hospitals in litigation involving the mentally disabled], the attorneys who prepare them have little interest and even less dedication").

> Mental health professionals would be under self-imposed pressure to find such alternatives rather than have to defend questionable hospitalization recommendations. The juvenile's attorney would also have an opportunity to add his or her resources and talents to the search. In some cases, the necessity for a hearing would be avoided because satisfactory alternatives to hospitalization would have been secured. Rather than discouraging people from seeking treatment for juveniles, services would be provided that were better fitted to the child's and family's needs.

"Confiict of Interest," *supra.*

See generally, Davidson, "That Other Helping Profession," 122 *Am. J. Psych.* 691, 692 (1965) ("[D]ue process may be annoying but it is a barricade to the march of tyranny"). Use of counsel in this context, furthermore, would help to correct the currently-existing situation (discussed at Point I.A., footnote 11, *supra,* at p. 9) in which "courts and attorneys . . . to a great degree have abdicated their responsibility," and in which "powers historically reserved for the legal system have slowly eroded." "Constitutional Crisis," *supra,* at 309.[62]

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[62] Another commentator has observed that "the judicial default reflected in the legal handbag of the mentally ill is certainly most egregious." Shah, "Some Interactions of Law and Mental Health in the Handling of Social Deviance," 23 *Cath. U. L. Rev.* 674, 712 (1974), cited in "Constitutional Crisis," *supra,* at *id.,* n.61.

Thus, an analysis of a mental health advocacy project in Pennsylvania noted favorably:

> Moreover, there was a general appreciation among all professionals interviewed that the Project had provided patients

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In fact, courts have consistently held that the right to counsel does apply to those proceedings "in which the liberty of an individual is at stake . . . whether [or not] the proceedings be labeled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency," *Heryford* v. *Parker,* 396 F. 2d 393, 396 (10 Cir. 1968); see also *In re Gault,* 387 U.S. 1 (1967).[63]

(Footnote continued from preceding page)

> with much-needed protection. One professional spoke of the Project as having reached out to patients who had "fallen between the slats". There was universal agreement that the project had highlighted for mental health professionals their own shortsightedness in dealing with patients, and their relative insensitivity to human and legal rights. There seemed to be gratitude expressed that the lawyers had accentuated what the hospital staff now perceived as a significant deficiency in their treatment of patients, and a readiness to change the previous patterns of awareness.

Steadman I, *supra,* at 30.

[63] Of course, in other areas of substantive law involving the rights of those institutionalized in psychiatric facilities, Federal courts have willingly applied to juvenile cases the reasoning of decisions originally rendered in matters involving adults. See, *e.g., Morales* v. *Turman,* 364 F. Supp. 166, 175 (E.D. Tex. 1973), supplemented 383 F. Supp. 53 (E.D. Tex. 1974), reversed and remanded 535 F. 2d 864 (5 Cir. 1976), reinstated —— U.S. ——, 97 S. Ct. 1189 (1977), applying the law of *Wyatt* v. *Stickney,* 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), aff'd *sub nom. Wyatt* v. *Aderholt,* 503 F. 2d 1305 (5 Cir. 1974) (right to treatment); *King* v. *Carey,* 405 F. Supp. 41 (W.D.N.Y. 1975), applying the law of *Wyatt, supra* (applicability of Thirteenth Amendment), and *Souder* v. *Brennan,* 367 F. Supp. 808 (D.D.C. 1973) (right to compensation for labor providing consequential economic benefits to institution).

In cases involving the right of a mentally handicapped child to a free public education, see, *e.g., Pennsylvaia Association for Retarded Children* v. *Pennsylvania,* 343 F. Supp. 279, 303-306 (E.D. Pa. 1972) [hereinafter *P.A.R.C.*], wherein each child is entitled to a due process hearing as to his placement and/or special class assignment, such judicial intervention had been seen by some as "a substantial threat to the stability of the education system," Weintraub and Abeson, "Appropriate Education for all Handicapped Children: A Growing Issue," 23 *Syr. L. Rev.* 1037, 1057 (1972), as an infringement upon the "exclusive province of the schools," Kirp and Kirp, "The Legalization of the School Psychologists' World," 14 *J. School Psychol.* 83, 87 (1976),[64] and had been greeted, in some quarters, by "willful noncompliance" on the part of school districts, "Legal Reform," *supra,* at 52, quoting First and Interim Report of the Masters at 69 (filed Aug. 2, 1973), in *P.A.R.C., supra,* and by "resistance" on the part of many vocational educators, "Legal Reform," *supra* at 71-72. See generally, Herr, "Retarded Children and the Law: Enforcing the Constitutional Rights of the Mentally Retarded," 23 *Syr. L. Rev.* 995 (1972).

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[64] Similarly, following the decision of the District Court in *Mills* v. *Board of Education,* 348 F. Supp. 866, 875 (D.D.C. 1972) (due process requires a hearing prior to "exclusion, termination or classification into a special program"), a teachers' union leader direly warned that his group could not be "held responsible for the education of any child in the district while forced [by *Mills*] to keep unruly children in school." Kirp, Buss and Kuriloff, "Legal Reform of Special Education: Empirical Studies and Procedural Proposals," 62 *Calif. L. Rev.* 40, 89 (1974) [hereinafter "Legal Reform"], quoting *Washington Post,* May 2, 1973, at C-1, Col. 7. *Cf. Goss* v. *Lopez,* 419 U.S. 565 (1975).

Interestingly, although counsel at due process hearings was not made mandatory,[65] parents represented by counsel were "significantly more likely to win a favorable ruling" than those not so represented, "Legal Reform," *supra,* at 79, results which closely parallel findings of similar surveys involving involuntary civil commitment hearings, see, *e.g.,* articles cited at Point II, p. 41, *supra.* Significantly, in discussing the scope of the due process hearing, Kirp, Buss and Kuriloff point out:

> It is wrong, of course, to assume that the parents' and the child's interests will never vary. Sometimes they will clearly conflict. For example, a parent may want to "get rid of" a child he considers a nuisance or a burden, or might resist appropriate and beneficial placement in a particular special education program because he fears some resulting stigma. Often such conflicts cannot be detected, and, to some extent, parent-child conflicts must simply be tolerated. Nevertheless, the governing procedures should include a provision for appointment of a guardian *ad litem* to represent the child's separate interests when there is evidence of a significant conflict of interest.

"Legal Reform," *supra,* at 125-126.

Finally, if a child is not afforded due process, it is likely that the resulting institutionalization will not result in any "lasting peace" in the family. "Conflict of

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[65] Under the *P.A.R.C.* decree, a parent is notified he has the "right to be represented at the [due process] hearing by any person of his choice, including legal counsel," 343 F. Supp. at 304, but no explicit provision is made for appointment of counsel to the indigent.

Interest," *supra.*[66] It has been suggested, thus, that judicial nonintervention supports the integrity of the family unit only in the sense that it allows the parents in a dysfunctional family to deny the existence of real family problems by "blaming them on the illness of one of their children." "Volunteering Children," *supra,* at 854-855.[67] Such "artificial domestic tranquility," "Conflict of Interest," *supra,* should not serve as a rationalization for the denial of procedural due process. In this context, the suggestion by appellants' expert witness that "dirty linen" should not be aired must be emphatically rejected.

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[66] As noted in a lengthy analysis of problems posed by medical treatment of minors, "Preservation of the family relation in the medical setting is better accomplished by an honest and clearly articulated separation of the interests and obligations of each of the participants. The family relation has value only in the worth that the members place upon each of the other members." "Removing the Barrier," *supra,* at 71.

[67] Significantly, in the course of an article otherwise advocating parental autonomy and minimal state supervention in juvenile medical care matters, Joseph Goldstein carves out a major exception in the area of mental illness. Goldstein, "Medical Care for the Child at Risk: On State Supervention of Parental Autonomy," 86 *Yale L.J.* 645, 661 (1977). He notes specifically:

> In the case of "mentally ill" 16-year-olds, these modifications of parental autonomy silently rest on a not totally unwarranted suspicion that mental institutions provide little, if any, medical treatment, and more openly upon a fear of parental abuse, not unlike the exploitation of the system by members of a family wishing to put a difficult spouse, parent, or sibling out of sight. The reasons which seem to underlie renewed challenges to the commitment of adults for mental health care without their consent prompt and seem to justify a limited emancipation of children in this area.

Id. (footnote omitted).

The District Court in *Bartley* v. *Kremens,* 402 F. Supp. 1039 (E.D. Pa. 1975), vacated and remanded on other grounds —— U.S. ——, 97 S. Ct. 1709 (1977), astutely concluded that the application of due process would provide the necessary balance between the rights of parents and children in the particular area of commitment proceedings. That decision in no way denigrated the importance of the family; rather, it encouraged families to settle their problems in an open and equitable manner. The court's respect for the family is evidenced in its statement that:

> This finding does not mean that when considering whether or not to institutionalize a child, the state should ignore the opinions and observations of the child's parent. Rather the commiting authorities should listen carefully to parents who live with and observe the child on a daily basis for they very likely have invaluable information concerning their child. 402 F. Supp. at 1048.

One commentator, thus, has pointed out that the *Bartley* District Court's opinion "emphasizes . . . factfinding, not blamelaying," Note, 48 *U. Colo. L. Rev., supra,* at 258, adding that the *Bartley* safeguards "are likely to reassure parents that their child's best interests will be served," and that "*Bartley* procedures may be the most effective means of protecting the best interests of the child," *Id.*[68]

Thus, it appears that the imposition of procedural due process protections will not inure to the juveniles' detriment, but, rather, that such protections will insure that no

[68] The article in question specifically notes that this proposition is supported by the New Jersey experience. *Id.*

other patients will ever "fall . . . between the slats," Steadman I, *supra,* in a context which will "contribute substantially to family understanding and harmony in addition to protecting the interests of the child," "Conflict of Interest," *supra.*

CONCLUSION

On the basis of the foregoing, it is respectfully submitted that the judgment and decree of the District Court should be affirmed.

Respectfully submitted,

STANLEY C. VAN NESS
Public Advocate
State of New Jersey
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Date: August 22, 1977

[APPENDIX FOLLOWS]

APPENDIX

Letter from Joseph J. Levin, Jr., Counsel of Record for Appellees, and R. Douglas Lackey, Assistant Attorney General, State of Georgia to Mr. Michael Rodak, Clerk, U. S. Supreme Court

GEORGIA LEGAL SERVICES PROGRAMS
Central Office
Suite 2121 101 Marietta Towers
Atlanta, Geogia 30303
(404) 656-6021 GIST 221-6021

August 25, 1977

Mr. Michael Rodak
Clerk, U. S. Supreme Court
Washington, D. C. 20543

Re: *Parham* v. *J.L. and J.R.*, U.S. Supreme Court Docket No. 75-1690, Consent To Filing of Amicus Briefs

Dear Mr. Rodak:

This is to inform the Court that counsel for both parties have agreed to the filing of the following amicus briefs in the above case:

1. American Bar Association
2. The Mental Health Law Project
3. Children's Defense Fund
4. Youth Law Center on behalf of the Child Welfare League of America

Letter from Joseph J. Levin, Jr., Counsel of Record for Appellees, and R. Douglas Lackey, Assistant Attorney General, State of Georgia to Mr. Michael Rodak, Clerk, U. S. Supreme Court

5. American Psychiatric Association
6. Department of the Public Advocate Division of Mental Health Advocacy State of New Jersey

Sincerely,

s/ JOSEPH J. LEVIN, JR.
Counsel of Record for Appellees

s/ R. DOUGLAS LACKEY
Assistant Attorney General,
State of Georgia

JJLJr:mhw

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

RICHARD J. HUGHES
Chief Justice

State House Annex
Trenton, New Jersey
No. 4-74

November 12, 1974

MEMORANDUM TO: All Assignment Judges, Trial Court Administrators and County Clerks

FROM: Chief Justice Richard J. Hughes

RE: Involuntary Civil Commitment Proceedings

A study recently conducted by the Administrative Office of the Courts indicates that there is a lack of uniformity among the counties in regard to the docketing procedures being followed in civil commitment cases. A great divergence of practice occurs in involuntary proceedings, where in many instances, papers are not filed until after the final judgment of commitment. (See N.J. S.A. 30:4-56). In addition, lack of adequate docketing procedures has permitted uncontrolled administrative adjournments so the court does not have a written record of the patient's confinement. When notice is filed in the County Clerk's Office, no docket number has been assigned for further control.

In order to standardize procedures throughout the State, all involuntary civil commitment cases shall be handled in the manner described below.

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

1. DOCKETING

It shall be the responsibility of the Assignment Judge, either personally or through his Trial Court Administrator, to generally supervise the docketing of all involuntary civil commitment proceedings.

Assignment Judges shall arrange with all hospital facilities in their respective vicinages, so that within 72 hours of accepting a person for treatment, they will have forwarded written notification of this acceptance to the following: the County Clerk; the County Adjuster; the patient; and the patient's nearest relative. The Department of Institutions and Agencies will be contacting all state-run facilities directing them to forward notification in the prescribed manner.

Upon receipt of the above notification, it shall be the obligation of the County Clerk to docket the matter in the County Court. All such proceedings shall be docketed according to county, and in the following manner:

County	*Code*	*Case Number*	*Year Committed*
Atlantic	ATCC	1	74
Bergen	BECC	1	74
Burlington	BUCC	1	74
Camden	CACC	1	74
Cape May	CMCC	1	74
Cumberland	CUCC	1	74

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

County	*Code*	*Case Number*	*Year Committed*
Essex	ESCC	1	74
Gloucester	GLCC	1	74
Hudson	HDCC	1	74
Hunterdon	HNCC	1	74
Mercer	MECC	1	74
Middlesex	MICC	1	74
Monmouth	MNCC	1	74
Morris	MRCC	1	74
Ocean	OCCC	1	74
Passaic	PACC	1	74
Salem	SACC	1	74
Somerset	SOCC	1	74
Sussex	SUCC	1	74
Union	UNCC	1	74
Warren	WACC	1	74

Consequently, "ATCC 1-74" would refer to the first civil commitment case docketed in Atlantic County in the calendar year 1974.[1]

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[1] Cases shall be docketed on a calendar year, rather than court year, basis. This conforms with the practice now prevalent in the county courts.

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

2. Assignment of Cases

Assignment Judges shall be given full discretion to assign civil commitment cases.

3. Scheduling of Cases

It shall be the responsibility of the County Clerk to assure that civil commitment hearings on the final order are held within 20 days from the date of initial commitment.

4. Written Notification of Hearing

It shall be the responsibility of the County Clerk to forward written notification of the time and place of the final hearing to the following: the County Adjuster; any assigned or retained counsel for the patient; the patient's nearest relative; and the plaintiff. Written notification shall be served personally upon the patient in accordance with N.J.S.A. 30:4-41.

In all instances mentioned above, written notification shall be transmitted no later than 5 days prior to the date of the hearing.

5. Adjournment Policy

It shall be the responsibility of the Assignment Judge to effectuate either a judgment of commitment or release of the patient as expeditiously as possible; therefore, in

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

the absence of extraordinary circumstances there shall be no more than one adjournment, which shall only be granted for good cause shown, and the duration of which should not exceed 10 days. If more than one adjournment is granted, a copy of the Order Granting Adjournment, with reasons therefore, shall be forwarded to the Division of Civil Practice, Administrative Office of the Courts, attention Cynthia Jacob.

6. Change in Patient's Status

Assignment Judges shall arrange with all hospital facilities in their respective vicinages to have the medical director or chief of service of said hospitals forward timely notification (which shall be construed as no less than 72 hours if a court hearing has been scheduled) of any substantive change in status to the following: the County Clerk; the County Adjuster; any assigned or retained counsel who may have represented the patient at the last review; the patient's nearest relative; and the plaintiff. Substantive change shall include, but not be limited to: death; discharge; transfer; unauthorized departure; conditional release and return therefrom.

7. Periodic Review

a. It shall be the responsibility of the Assignment Judge to supervise the periodic review of all persons who are now, or may hereafter become, involuntarily committed in their vicinage. For such purposes, docket numbers shall be assigned in the manner described above,

with the last two digits reflecting the calendar year of initial commitment.

For all cases initiated after the effective date of this order, the following schedule shall be adopted:

1. A review of the proceedings 6 months after the date of final commitment.
2. A review of the proceedings 12 months after the date of final commitment.
3. A review of the proceedings 18 months after the date of final commitment.
4. A review of the proceedings 30 months after the date of final commitment.
5. A review of the proceedings every two years thereafter.

b. In all cases in which the patient had already been committed prior to the effective date of this order, the following schedule shall be adopted:

1. All patients committed 10 years or more shall have their cases docketed and reviewed by March 1, 1975 with a further review every 2 years from the date of the last review.
2. All patients committed 5-10 years shall have their cases docketed and reviewed by June 1, 1975, with a further review every 2 years from the date of the last review.
3. All patients committed 30 months to 5 years shall have their cases docketed and reviewed by September 1, 1975, with a further review every 2 years from the date of the last review.

4. All patients committed less than 30 months shall be reviewed in accordance with paragraph (a) of this section.[2]

It shall be the obligation of the County Clerk to assure that proper notification of the review shall be given to: the County Adjuster; the executive director or chief of service of the hospital in which the patient is confined; the patient; any assigned or retained counsel for the patient; the patient's nearest relative; and the plaintiff.

Unless requested by any of the parties mentioned in the preceding paragraph, it shall remain within the court's discretion whether to accomplish the review summarily or by means of a plenary hearing; however, if specifically requested, a hearing shall be scheduled.

8. Patient's Right to Appear

It shall be the responsibility of the Assignment Judge to assure that in all instances in which a hearing has been scheduled, that the patient be given every opportunity to appear. If the medical director or chief of service of the mental hospital feels that in his expert opinion it would

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[2] Officials at the Department of Institutions and Agencies have assured us that they presently are preparing an internal review of each patient's status on a semi-annual basis. Accordingly, there will be no administrative burden placed upon the institutions themselves in complying with this section of the Directive.

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be prejudicial to the health of the patient, or unsafe to produce the patient at the inquiry, then it shall be the obligation of the medical director or chief of service to certify in writing to the court his expert opinion concerning the patient's inability to appear, setting forth the facts supporting his conclusion. The hearing judge shall evaluate any certification submitted and determine whether the personal appearance of the patient is feasible. (See N.J.S.A. 30:4-41).

The policy and procedures set forth in this memorandum shall take effect immediately.

cc: County Counsels
County Adjusters
Department of Institutions and Agencies